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AUTHOR Moy, Caryl T.
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ABSTRACT

The use of touch in therapeutic relationships is seldom dealt with as a practice issue except in a proscriptive way. To gather descriptive information on the use of touch in therapy, professional therapists (N=50) whose practice was largely family therapy were interviewed about the successful use of touch in their helping relationships. Interview responses were coded for general demographic variables, family background and affective patterns. Family factors identified as influencing the therapists' use of touch were birth order, church attendance, warm family relationships, and the presence of both parents in the home at least through puberty. Responses revealed a continuum of opinion about the extent to which touch enhances the treatment process ranging from its use as only one of many effective counseling techniques to a view in which touch was seen as making a more spontaneous, human therapy relationship. The findings suggest that instruction about the use of touch should be incorporated in professional therapy curricula, with the understanding that its effectiveness may be determined by a combination of the therapist's human and professional reactions. (MCF)

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TOUCH IN FAMILY THERAPY: AN EXPLORATORY STUDY REPORT

Caryl T. Moy, Ph.D.
Sangamon State University
Springfield, IL

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TOUCH IN FAMILY THERAPY
AN EXPLORATORY STUDY REPORT

Touch plays an important part in expressing encouragement and tenderness, and in showing emotional support. It is the first sensation to which each newborn infant responds. But as a child grows, words (which are distant and symbolic) replace touch (which is intimate and close) as the primary means of communication. Through myriad cultural messages, our children learn to restrict physical contact with others to socially acceptable and culturally determined forms of touching, such as a formal handshake or a pat on the back. By the time they are adults, they have shifted from touch to words as their primary form of communication. When we think about it we realize each family therapist's own family has given a cultural message of acceptable or unacceptable behavior on this issue. As the formal handshake in my family may seem stiff to those of you who may come from a family of huggers.

The philosophy which rejects the use of touch in the therapeutic relationship has its roots in classical Freudian psychology.[1] Strict interpreters of Freud have insisted that there should be no physical contact between the psychiatrist and the patient, or the helper and the help-seeker. Menninger went so far as to regard any physical contact on the part of a therapist as "criminal ruthlessness."[2] With the influence of the humanistic philosophy of helping, based on strong person-to-person relationship, this prohibition against physical contact between helper and help-seeker is being re-evaluted.

In reviewing the literature I found, there has been little systematic instruction about the issue of touch. The topic is not routinely included in professional curricula, yet all those in professions utilizing the therapeutic relationship must deal with the use of touch in some way at some time, even by deciding not to use it. The purpose of the present study was to explore the successful use of touch by surveying the opinions and practices of health professionals who use touch in their helping relationships. It was not done with non-touchers in this study with 35 subjects, 19 either identified themselves as family therapists or a large portion of their professional work was family therapy. The study was designed to provide descriptive information, data which have been lacking. Many educators have suggested the positive value of this aspect of counselor behavior, but usually descriptions of the situations in which touch has been successful are not included in theory and practice literature.

TOUCH

Touch was defined as a form of non-verbal communication in which one's hands or arms make contact with another person in the promotion of the therapeutic process.

Fifty professionals were randomly selected from a pool of 200 health professionals. All were sent a letter of introduction and explanation which asked if they comfortably used touch as part of their therapy technique, and if they would be willing to be interviewed. A copy of the interview questionnaire was included. A follow-up phone call to each indicated that thirty-five professionals (19 men, 16 women) met the requirements.

A survey instrument was developed to gather descriptive information from the subjects. I began by asking them to tell something about themselves that

might relate to their opinions or feeling about touch. I was interested in their family background, their family's affection patterns, their family's expression of touch. I'd also wanted to know about religious and ethnic influences and their geographic area of origin - general demographic variables. Next I asked for professional training and experience, the year they received their last professional degree, their theoretical orientation in helping, the number of years in practice. I asked what professional exposure to the issue of touch have they had that has affected the origin or development of their philosophy of touch? (For example, within a class, with a mentor or other significant person, or with a special experience.) I next moved to get a description of the use of touch, circumstances under which touch is initiated, part of the patient or client on which touch is likely to occur, intentions likely to be conveyed through touch, context factors affecting the decision of touch, physical setting in which touch would likely occur, circumstances when purpose of touch would likely occur, circumstances when purpose of touch was misinterpreted, critical incidents involved when touch had a negative effect, and critical incidents involved when touch had a positive effect. The instrument contained a series of open-ended questions designed to provide the opportunity for answers to be as extensive as the subject wished.

All interviews were conducted in professional offices, and all were tape recorded. Transcripts were made of each interview, then the responses were coded.

FAMILY BACKGROUNDS

A number of family background factors were identified in this study. Nineteen of the subjects were first-born children. Twenty subjects reported that their entire family attended church regularly. All but three subjects

reported some family religious participation. Interestingly, none of the three were family therapists. Those family therapists with a pastoral care background or strong religious training acknowledged how their religious training affected the attitude toward touch. A typical response here was:

> "Probably part of my background tells me some way or another that touching is a kind of intimacy that is less than necessary or professional. There's something in there that goes on like that, Now I don't follow it, but I think that there's something still left there."

The integration conflict of affective and intellectual still lingers. It was impressive at how many subjects indicated a strong perception of having been well nurtured. Typical of the statements about the positive nurturing they felt by the subjects are, "I was a very much wanted child.", and "I feel like we were a very close family; we shared a lot." "There was a lot of warmth and we enjoyed each other." "My mother was a very warm person, my father was fairly, I don't know the best way to put it, was reserved I guess."

All but one subject felt well nurtured. In all cases there was a presence of both parents in the subjects' homes at least through puberty. It appeared that these subjects had backgrounds which could reasonably be assumed to provide an environment for healthy development. It is probably not surprising that these persons are comfortable reaching out to others.

Only twenty percent (N=7) of the entire study reported having the topic of touch covered in any formal class discussion and then several said it was proscription to not touch i.e. "Don't mess up young men's lives." Eighteen (55%) stated that they had developed their ideas about the use of touch primarily through gradual professional self-awareness. One family therapist described his learning

process as follows:

> "Well, certainly in my psychology training it was a no-no. Even the fact that I was trained as a child therapist initially, theoretically we were taught not to touch anything. I happened to have a supervisor who felt very differently about that so there was frequent use of touch with the children, holding them on the lap, holding hands, and things like that. So I was taught one thing and actually allowed to do something quite different. It was not until I went into active forms of therapy, such as psychodrama, that touch really became a really very viable alternative. From that point on I have been very comfortable with touch. I still am.

Although no theoretical orientation appeared to be dominant in the entire study, when the subjects described their own helping orientations certain phrases were repeated which conveyed a common philosophy, All family therapists avowed a systems approach. They along with other subjects become involved with the patients or clients as whole persons. They encourage responsibility on the part of the helpseekers. They share a "growth orientation." They work toward lessening their patients' dependence and increasing their freedom.

CONTEXT ISSUES

Touch was most likely to be used when client families were in crisis situations or expressing pain or sorrow. The place most often touched was a hand. However, proximity to the therapist influenced where they touched, and in some

cases they would touch a foot or a toe.

These therapists found touch moderately important in the total context of their counseling. On a scale of 1 (low) to 5 (high), subjects ascribed a mean level of 3.9 to the importance of touch. Family therapists had the same mean levels.

All subjects valued touch as part of their professional repertoire, a tool to use when appropriate. One family therapist expressed this value most articulately.

> "To me the therapeutic session is <u>the</u> most intimate relationship almost, apart from a marriage or a very close friendship, because people are telling you their most inner world. And I think that touch belongs in initimate relationships, not a sexual relationship, but an intimate relationship and not to add that. And here's what I really feel is important: Touch must be equal between clients, If a male therapist can only touch women, they're homophobic and I think they miss a crucial dimension, because I get to feeling intimate with my male clients as well as with my female clients. And to me, touch seems to be just as crucial there. It's the human factor not the sexual factor that is there."

A common thread of expression about the primary intention of touch was to convey caring, or express withness:

> "I am saying in some way that you are not alone, I am with you, I care about you, I am interested in you.

I am trying to convey messages that perhaps might not be conveyed verbally."

One family therapist shared that in working with families he models with children, making a conscious effort to touch the children particularly if he feels it is a touch phobic family that is not touching. Another stated that if it is a family where child abuse is a part, where the only facet of touch that they would have experienced would have been in anger, then she would use touch to teach that it can be supportive. Assessing how the touch would be interpreted was the single most influential factor in the subjects decisions to touch or not to touch.

Twenty-three percent of the subjects said they were most influenced by the sex of the patient before deciding to use touch. However, there was no significant relationship between the patient's sex and the effect of touch in the relationship, when analyzed by Chi-square.

One subject expressed a common reaction: "Sex of the person I'm helping is a variable that influences my decision, but I'm not biased in one way or another. I just have to consider different issues in the way that I touch and whether to do it."

All subjects stated that they prevented a sexual interpretation of therapeutic touch by not touching any part of the body that could be considered erotic. Twenty-five percent verbalized to the patient their intention in touching them as a precaution against misinterpretation.

Typical of positive outcomes described when a client was in crisis is the following illustration from a family therapist, a man:

"There was a bi-sexual minister who had been stopped by the police and they'd written down all the material about him. When he came in that day, I simply put my arms around him and I held him and he wept on my shoulder. He's gone back

to that incident again and again. Then he quoted this client as exclaiming, 'I never really wanted sex with a man, but I just need a man to let me know that I'm really ok. No one ever did that for me before.'"

Improved behavior change occurred following the touching experience on over one-third of the positive situations, and when negative effects were reported, subjects often stated that they used the misinterpretation as a clarifying point in a treatment process.

When questioned about memorable happenings, either negative or positive, a hug was the most frequently cited manner of touching. Two of three times that a hug was reported as the manner of touching, the outcome was described as positive.

Though the counselors expected that they were most likely to touch a hand, when questioned about their positive and negative experiences the kind of touch most often described for both categories was "the hug" as in the example I gave you. In our therapeutic work it appears that this kind of touch carries with it the highest potential usefulness, but also the greater risk for misinterpretation.

The most usual client response reported in the critical incidents was that feelings were verbalized as a result of the touch. When they perceived the effect of touch as positive, thirty-four percent of the subjects also stated that the therapeutic interactive process improved after the touch. Patients' descriptions when the outcome of touch was negative were reported as: "verbalized negative feelings," "pulled away," "jumped as if frightened," "face tightened up," and "negative body language."

Twenty-nine percent of the subjects stated that incidents which they reported positive or negative did not have any effect on their philosophy of touch. However,

most subjects stated that they interpreted negative effects as a specific therapeutic mistake and not as an indication to reconsider the therapeutic use of touch.

Whenever the topic of touching in helping is raised, concerns about sexuality are also raised. The findings indicate this is an acknowledged concern for counselors but one with which they deal openly within their own professional awareness. Men are more likely to misinterpret touch than women. The sex of the counselor in these situations was not significant. However, this finding emphasizes the need to be continually aware of the kind of cultural programming families are likely to have experienced concerning touch.

There is a continuum of views on the extent to which touch enhances the treatment process. At one end are those who view it as one of many effective counseling techniques, to be used in a very conscious manner. At the opposite end are those who use touch more spontaneously, breaking through the strict therapeutic relationship to relate in a human-to-human way. There is no formula for touching. Since there is always an element of potential risk of misunderstanding in touching, a professional judgment about appropriateness must be made in each situation.

The professional experiences described in this study provide a baseline to assist young therapists in making decisions about a professional use of touch and judging its risks. After considering the issue of touch and its associated risks, counseling professionals can better weigh whether their own use of touch will contribute to better care for their clients.

One comment from a pastoral psychotherapist who participated in the study expressed it well:

"I really believe that touch is very, very helpful in the helping professions..,especially since we're living in a world with people who are skeptical that there are people who care about them. If we can only convey that!"

All therapists must deal with the use of touch in some way, at some time, within their professional experience--even if their final decision is not to use it. Instruction concerning touch and discussions of its value can be systematically incorporated into our professional therapy curricula. However, this discussion must include the understanding that, quite possibly, touch cannot be taught by prescription. Its effectiveness may be determined by a combination of the therapist's human and professional reactions with the family system.

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